New Jersey Department of Health and Senior Services

BUDGET REVISION REQUEST

Attach justification for each category revision on a separate sheet

Reporting Agency			Grant Title		
Address			Budget Period FROM: TO:		
City	State	Zip	Grant No.	Account No.	Revision No.

BUDGET CATEGORIES	ROUND OFF TO NEAREST DOLLAR					
	APPROVED BUDGET		REQUESTED CHANGES*		REVISED BUDGET	
	Grant Funds	Other Funds	Grant Funds	Other Funds	Grant Funds	Other Funds
A. PERSONNEL COST						
Salaries/Wages						
Fringe Benefits						
Total						
B CONSULTANT/PROFESSIONAL SERVICES COST						
Total						
C. OTHER COST CATEGORIES						
Office Expense and Related Cost						
Program Expense and Related Cost						
Staff Training and Education Cost						
Travel, Conferences and Meetings						
Equipment and Other Capital Expenditures						
Facility Cost						
Sub-Grants						
Total						
Total Direct Cost						
Indirect Cost						
Total Cost						
Less Program Income						
NET TOTAL COST						

Name of Chief Financial Officer		State Approvals				
Title			Yes	No	Date	Signature
Signature	Date	Program Mgmt. Officer	☐	☐		
		Grant Management Officer	☐	☐		

FS-57
JUL 05

*Use Plus (+) or Minus (-) signs to indicate additions and subtractions.